

*Pol accepted*  
3/7/06

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  02269104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/17/2006
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NAME OF PROVIDER OR SUPPLIER  JEANNE JUGAN RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 HAREWOOD ROAD NE WASHINGTON, DC 20017
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments  An annual licensure survey was conducted on February 16 through 17, 2006. The following deficiencies were based on observations, staff interviews and record review. The sample included 10 residents based on a census of 29 on the first day of survey.	L 000		
L 099	3219.1 Nursing Facilities  Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by a dietary staff person handling silverware without wearing gloves and soiled metal sensor wires under cooking hoods. These findings were observed in the presence of the Food Service staff.  The findings include:  1. A dietary staff person on the Good Shepard Unit was observed handling silverware (knives, forks and knives) without using gloves in one (1) of one (1) observation at approximately 12:50 PM on February 16, 2005.  2. The Ansul Fire Suppressor sensor wires under cooking hoods were soiled with accumulated grease and dust in one (1) of two (2) observations at approximately 8:40 AM on February 16, 2005.	L 099	1. The dietary staff person responsible for handling silverware without gloves has been instructed to use gloves when separating clean silverware and when setting them at table.  2. All dietary staff will use gloves when separating clean silverware and when setting them at table.  3. To ensure that foods are served in a safe and sanitary manner in accordance with the requirements set forth in Title 23, subtitle B.D.C. Municipal Regulations (DCMR), chapter 24-40, an inservice has been conducted for all dietary aides by the dietary manager regarding the proper procedure used in handling clean silverware.  4. The dietary manager will monitor, on weekly intervals, the table setting by dietary aides in Good Shepherd Dining Room.  Mandatory annual inservice	02-18-06  02-18-06  02-18-06  03-01-06  06-14-06

Health Regulation Administration  
*L. Cecilia Sartorius* Administrator  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
 (X6) DATE 3/2/06

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02269104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEANNE JUGAN RESIDENCE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4200 HAREWOOD ROAD NE WASHINGTON, DC 20017</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 1	L 410		
L 410	3256.1 Nursing Facilities  Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility was not maintained in a safe and sanitary manner as evidenced by marred and splintered entrance, bathroom and closet doors. These findings were observed in the presence of the Housekeeping and Maintenance staff.  The findings include:  1. Resident's entrance, closet and bathroom doors were marred and splintered on the frontal and edge surfaces in rooms 1201, 1207, 1209, 1217, 1223, 1407, 1416 and 1420 in eight (8) of 16 observations between 1:10 PM and 2:15 PM on February 17, 2006.	L 410	1. Immediate repair of door edges with putty, sanding, stain will be done to rooms #1201, 1207, 1209, 1217, 1223, 1407, 1416 and 1420. 2. To identify other potential problems, maintenance will inspect all Residents' doors. A log will be kept of doors needing repairs will be completed by 05-03-06. 3. We will add these door inspections to the quarterly Preventative Maintenance program. 4. We will include the doors on semiannual inspection list to see that Preventative Maintenance program is being adhered to.	03-10-06  05-03-06  03-03-06  06-30-06
L 099	(continued from sheet 1 of 2) 3219.1 Nursing Facilities	L 099	(continued from sheet 1 of 2) for dietary aides on "food Handling" covers the safe and sanitary procedure of handling clean silverware and tableware.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09E020	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  02/17/2006
NAME OF PROVIDER OR SUPPLIER  JEANNE JUGAN RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 HAREWOOD ROAD NE WASHINGTON, DC 20017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The annual Life Safety Code survey was conducted at your facility on February 17, 2006. There were no deficiencies cited.	K 000	<p style="text-align: center;"><i>Jeanne Jugan</i> 2006</p> <hr/> <p style="text-align: center;"><i>Jeanne Jugan</i> — Fire — 2006</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*S. Cecilia Sartorius* *Administrator* *3/2/06*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.